

Physician _____ Chart Number _____

Patient Information

Palmetto Health USC
MEDICAL GROUP

Patient Name (first, middle, last) _____

Social Security # _____ Birth Date _____ Sex M F

Marital Status: Single Married Separated Divorced Widowed Life Partner

Address _____

City/State/Zip _____

Phone: Home _____ Cell _____ Work _____

Email _____

Ethnic Origin: Native American Asian Black Hispanic White Other _____

Primary Language _____

Referring Physician _____ Pharmacy _____

Emergency Contact Information

Name _____

Relationship to Patient _____ Phone Number _____

Guarantor Information (Financially Responsible Party)

Check if information is same as above

Name (first, middle, last) _____

Social Security # _____ Birth Date _____ Sex M F

Marital Status: Single Married Separated Divorced Widowed Life Partner

Address _____

City/State/Zip _____

Phone: Home _____ Cell _____ Work _____

Guarantor's Relationship to Patient _____

Employer Name _____ Occupation _____

Address _____

City/State/Zip _____

Release of Information

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am responsible for any amount not covered by my insurance. I request that payment of authorized Medicare benefits be made to my physician.

Signature of Patient (Parental Signature if Minor) _____ Date _____